BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association.

Prescription Drug Claim Form

ONE CLAIM FORM PER PATIENT.

INSTRUCTIONS: Print or type clearly and accurately. If you are completing this form in Acrobat, simply "tab" from field to field.

SUBSCRIBER INFORMATION

1. BCBSNE ID Number: ALPHA PREFIX / NUMBERS / PLAN CODE

2. Subscriber's Daytime Phone Number: AREA CODE / TELEPHONE NUMBER

3. Subscriber's Name: LAST NAME / FIRST NAME / M.I.

4. Subscriber's Address: Street: / City: / State: / Zip: –

5. Date of Birth: PLEASE ENTER AS — M M D D Y Y Y Y

6. Sex: ☐ Male ☐ Female

PATIENT INFORMATION

7. Patient's Name: LAST NAME / FIRST NAME / M.I.

8. Patient's Address: Street: / City: / State: / Zip: –

9. Date of Birth: PLEASE ENTER AS — M M D D Y Y Y Y

10. Sex: ☐ Male ☐ Female

11. Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

12. Was a BCBSNE ID card issued to you at the time of fill? ☐ Yes ☐ No

I certify that the patient for who this claim is made is a covered person in the Rx Nebraska Prescription Drug Program and that the prescription is for the sole use of the named patient.

SIGNATURE OF NAMED CARDHOLDER OR MEMBER OF FAMILY

DATE

If you use a participating pharmacy, your prescription drug claims are filed automatically. However, you will need to complete and submit your claim form if:

- ► Your pharmacy does not have your insurance information on file.
- ► You do not have your Rx Nebraska ID card with you when you fill your prescription.
- ► You have your prescription filled at a non-participating pharmacy.

TO AVOID ANY DELAY IN THE PROCESSING OF YOUR CLAIM, simply follow these steps:

1. Complete the subscriber and patient information; questions 1-9 listed above.
2. Remember to SIGN the claim form where indicated.
3. Use a separate claim form for each patient.
4. Submit the ORIGINAL itemized pharmacy receipt with the claim form. The itemized pharmacy receipt must include: place of purchase, date of purchase, patient's name, Rx number, name of medication, cost of medication, quantity, day supply and NDC number.
5. Keep a copy of your pharmacy receipt for your personal/tax/medical records.
6. Mail your Rx Nebraska Prescription Drug Claim Form AS SOON AS POSSIBLE to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

If you have any questions, contact BCBSNE Member Services in Omaha (402) 390-1820 or toll-free 1-800-642-8980.